Employee's Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

See Instructions On Reverse

OMB No.1215-0160

3. Name of person making claim (Type or print)
First: Bert | Middle Initial: W. | Last: Meyer

1. OWCP No.

2. Carrier's No.

5. Claimant's address (number, street, city, state, ZIP code)
91-1023 Lipo Street
Kapolei, HI 96707

4. Date of injury (Mo./day/yr.)
10-1-02

6. Marital Status
Married

7. Sex
☒ Male ☐ Female

8. Age or date of birth (Mo./day/yr.)
4-7-67

9. Social Security Number (Required by law)
575 : 19 : 5133

10. Did injury cause loss of time beyond day or shift of accident?
☒ Yes ☐ No

11. On date of injury give
a. Hour began work 6:00 ☐ AM ☒ PM
b. Hour of accident 7:30 ☐ AM ☒ PM
c. Did you stop work immediately? ☐ Yes ☒ No

12. Date and hour pay stopped?
10-1-02 ☐ AM ☐ PM

13. Date and hour you returned to work
5-24-03, then off again
9-12-03 to present

14. Occupation (Job title: longshore worker, welder, etc.)
Longshoreman

15. Injured while doing regular work?
☒ Yes ☐ No
(If "No," explain in Item 24)

16. Wages or earnings when injured (include overtime allowances, etc.)
a. Weekly $

b. Total earnings during year immediately before injury. $80,000.00

17. Has 3rd party or other claim been made because of this injury?
☒ Yes ☐ No

18. Number of years you worked for this employer
7

19. Number of days usually worked per week
7

20. Name of supervisor at time of accident?
Danny Kaneala

21. Earliest date supervisor or employer knew of accident
10-1-02

22. Were you employed elsewhere during the week injured?
☒ No ☐ Yes (If "Yes," state where and when on reverse.)

23. Exact place where accident occurred (Street address, city, town, name of vessel, pier, terminal, etc.)
Aboard LIHUE, Matson Terminal, Pier 52, Honolulu, Hawaii

24. Describe in full how the accident occurred (Relate the events which resulted in the injury or occupational disease. Tell what the injured was doing at the time of the accident. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. If more space is needed, continue on reverse.)
Left foot went through opening between catwalk grating and hatchcover.

25. Nature of injury (name part of body affected - fractured left leg, bruised right thumb, etc. If there was a loss or loss of use of a part of the body, describe.)
Back, left hip, and groin.

26. Have you received medical attention for this injury?
(If "Yes," give name and address of doctor, clinic, hospital, etc.)
☒ Yes ☐ No
Steven Kaneshiro, M.D.

27. Were you treated by a physician of your choice?
☒ Yes ☐ No

28. Was such treatment provided by employer?
☒ Yes ☐ No

29. Are you still disabled on account of this injury?
☐ Yes ☐ No

30. Have you worked during the period of disability?
☐ Yes ☐ No

31. Have you received any wages since becoming disabled?
☐ Yes ☐ No (If "Yes," give dates on reverse)

32. Has injury resulted in permanent disability, amputation or serious disfigurement?
Unknown ☐ Yes (Describe on reverse.) ☐ No

33. Name of employer (Individual or firm name)
See attached page

34. Nature of employer's business
Stevedore

35. Address of employer (Number, street, city, state, ZIP code)
See attached page

36. If accident occurred outside the U.S., state whether you are a U.S. Citizen
☐ Yes ☐ No

37. I hereby make claim for compensation benefits, monetary and medical, under the Longshore and Harbor Workers' Compensation Act

Signature of claimant or person acting in his/her behalf
Bert W. Meyer
BERT W. MEYER

38. Date of this claim (Mo./day/yr.)
1-19-04

EXHIBIT A

Section 31(a)(1) of the Longshore Act, 33 U.S.C. 931(a)(1) provides, as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

Paragon Printing, Inc. - 8131 W. 10th Street - Indianapolis, IN 46214 - (317) 271-7310 - Fax (317) 271-7405 Form LS-203

33/35.

(a) McCabe, Hamilton & Renny Co., Ltd.
P.O. Box 210
Honolulu, Hawaii 96810

(b) Matson Terminals, Inc. (for insurance purposes only)
P.O. Box 2630
Honolulu, Hawaii 96803